

**WISCONSIN MEDICAID
RECIPIENT ELECTION OF MEDICAID HOSPICE BENEFIT**

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Provision of the information requested on this form is mandatory; however, the use of this version of the form is voluntary. Providers may develop their own version of this form as long as it includes all the information on this form.

Instructions: Type or print clearly. Keep this information in the recipient's records; *do not* send it to Wisconsin Medicaid.

Name — Recipient	Name — Hospice	Hospice's Medicaid Provider Number
Name — Attending Physician		Start Date for Hospice Services

I, the recipient named above, choose to receive hospice care from the hospice program named above. I acknowledge and understand the following:

- The hospice program is palliative, not curative, in its goals. This means that the program does not attempt to cure disease, but emphasizes the relief of symptoms such as pain, physical discomfort, and emotional stress that may accompany a life-threatening illness.
- By choosing Medicaid hospice benefits, I agree to receive all services from the hospice and attending physician I designated above.
- I can choose to discontinue hospice care at any time. To discontinue, I must complete a revocation statement. I can obtain this statement from the hospice coordinator.
- If I choose to withdraw from my Medicaid hospice benefit, I understand that I may re-elect hospice at a later time.
- I can choose to receive hospice care from another hospice program at any time. To change programs, I must first confirm that the hospice to which I wish to be admitted can admit me and on what date. I must inform my current hospice program of my wishes so that arrangements for the transfer can be made. I must document the date I wish to discontinue care from my current hospice, the name of the hospice from which I wish to receive care, and the date that care will start.

Acknowledging and understanding the above, I authorize the above-named hospice to begin providing Medicaid-covered services on the date indicated above. I designate the physician named above as my attending physician.

SIGNATURE — Recipient or Legal Representative		Date Signed
SIGNATURE — Witness	Name — Witness	Date Signed